V. S. No. 2
00M—2-43
Rev. 5-17-39
X35097

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 19012

FILED JUN 14 1944

Registration District No. 1944 Primary Registration District No. 6061 Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County St Clair
(b) City or town Gerster Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community 40 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County St Clair
(c) City or town Gerster Rural
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME EUGENE BURNS
3. (b) If veteran, name war no
3. (c) Social Security No. no
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife Frances E Burns
6. (c) Age of husband or wife if alive ... years
7. Birth date of deceased 4 (Month) 17 (Day) 1857 (Year)
8. AGE: Years 87 Months Days 28 If less than one day ... hr. ... min.
9. Birthplace (City, town, or county) N.Y. (State or foreign country)
10. Usual occupation Farming
11. Industry or business
FATHER 12. Name William Burns
13. Birthplace (City, town, or county) N.Y. (State or foreign country)
MOTHER 14. Maiden name Mary Kenny
15. Birthplace (City, town, or county) Ky (State or foreign country)
16. (a) Informant F. E. Burns
(b) Address Gerster Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-16-44 (Month) (Day) (Year)
(c) Place: burial or cremation King Grove
18. (a) Signature of funeral director Ordale F Home
(b) Address Osceola Mo
19. (a) 5/15/44 (Date received local registrar) (b) H. B. Frederick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15 year 1944 hour 1 minute 20 A M.
21. I hereby certify that I attended the deceased from May 13 1944, to May 15 1944, that I last saw him alive on May 13 1944, and that death occurred on the date and hour stated above.
Immediate cause of death Chronic Myocarditis Duration
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
93d
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury
23. Signature Dr. E. D. Brown (M.D. or other) DO
Address Collins Mo Date signed 5/15/44

(Licensed Embalmer's Statement on Reverse Side)

13
0
0

RECEIVED
District Health Officer No. 7,
District File Number 5-44-75-0
Date Filed 6-12-44

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed J B Frederick

Licensed Embalmer No. 3038

P. O. Address Osceola Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.